MARYLAND
DUALS CARE DELIVERY WORKGROUP

SEPTEMBER 20, 2016 | 1:00-4:00 PM

AGENDA

- Welcome and Introductions
- Recap of Duals Model Development
- Presentation on Primary Care Model and Population Health Strategy
- Recap of Subgroup Meetings
  - Care Redesign
  - Risk Adjustment
- Wrap-up, Takeaways and Next Steps
- Public Comment

RECAP OF JULY 29 MEETING

- Discussed geographies of D-ACO and MFFS model
- Further described the PCHH and its role in the duals initiative
- Presented member attribution methods for D-ACOs and PCHHs
- Discussed qualifications and requirements for D-ACOs
- Considered the role of MSSP ACOs and their dual beneficiaries if they do and do not operate as a D-ACO
- Discussed the role of data analytics and exchange in the duals initiative
- Discussed care coordination payments and risk adjustment methods that need to be considered for the diverse group of dual eligible beneficiaries

TIMELINE

Model decided upon and refinement begun

Sub-group meetings to refine model elements

Draft and submit concept paper

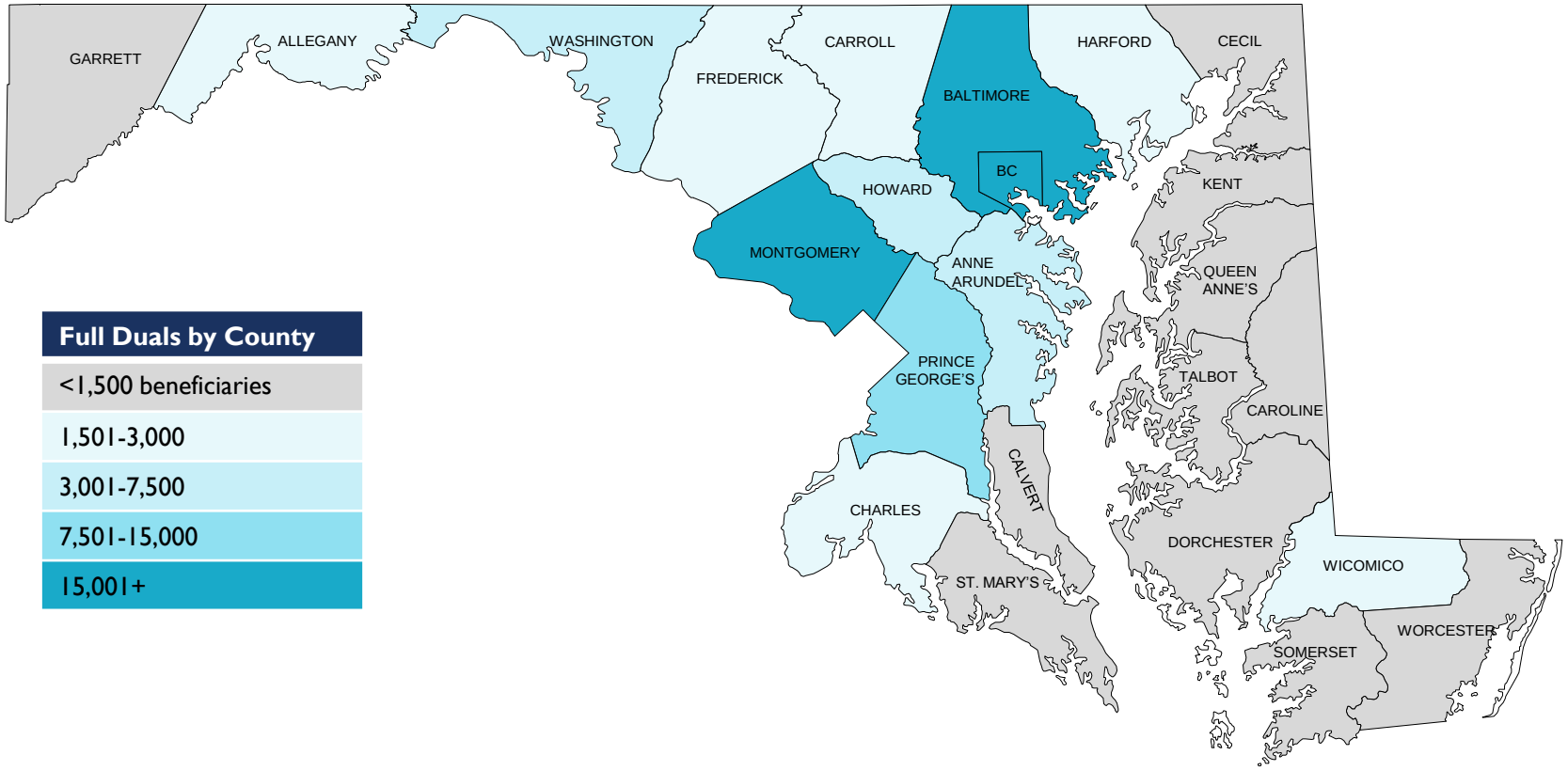
Discuss linkage to All-Payer Model and Primary Care Model

Program costs and budget neutrality calculations discussed

Affirm stakeholder interest

Waiver concepts drafted and discussed

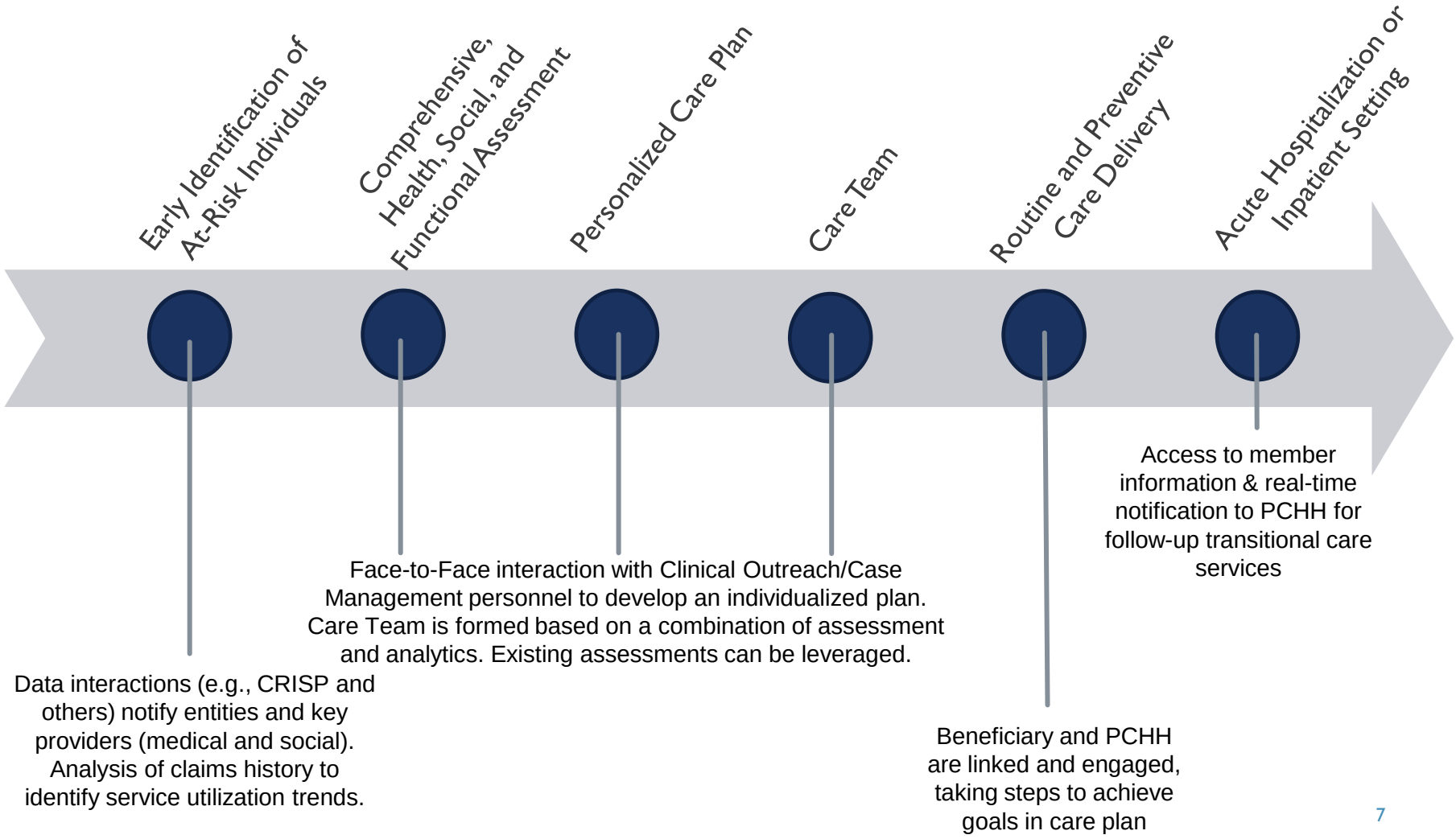
DISTRIBUTION OF FULL DUALS IN MARYLAND



CARE REDESIGN SUBGROUP OBJECTIVES

- Define the role and function of the Person Centered Health Home (PCHH), the Duals-Accountable Care Organization (D-ACO), and the Program Coordination Entity (PCE) across both parts of the hybrid model.
- Define the concept of the PCHH and what drivers need to be in place to transform how care is delivered, both in the D-ACO and MFFS models.
- Define how care will be integrated across payers and across settings – ensuring coordination between Medicare and Medicaid services and transitions of care.
- Define and set expectations of what will be expected of providers in the MFFS and D-ACO settings. Identify how providers will interact with one another and with varying entities including the PCHH, D-ACO, and PCE.
- Identify barriers to supporting the care delivery mechanism and consider implications and work-arounds.

CARE CONTINUUM FOR PERSON-CENTERED CARE



CARE REDESIGN DISCUSSION POINTS

- How do we define "at-risk" beneficiaries when we consider dual eligibles?
  - While the intent is to filter the population and identify those who need immediate attention, we should consider "at-risk" beneficiaries as those who not only have high utilization of services, but those with specific conditions or disease states
- Ensure the beneficiary (the patient) is considered within the context of their caregiver and the community.
- What type of person-centered care should be delivered?
  - What is the right combination and type of high-touch and high-tech approach?
  - How are care plans and data analytics individualized?

COMPREHENSIVE NEEDS ASSESSMENT

- Are there existing health (behavioral and physical) and social needs assessment tools that is applicable and can be integrated for dual eligibles?
  - InterRAI
  - DLA-20
  - Others?
- Are there ways to leverage existing assessment processes? What are some existing processes that should continue to operate?
  - Are these instruments currently computerized and cross-linked to data sets?
  - Who should conduct the initial risk assessment, how (in-person or telephonic), and how often should it be conducted?

CARE REDESIGN DISCUSSION POINTS

- Should the D-ACO model spill into border areas where beneficiaries still have access to care? And, should the D-ACO model be offered in conjunction with the MFFS model?
  - Can this be achieved without creating the ability for PCHHs to "cherry-pick" beneficiaries based on risk?
- What expectations should D-ACOs be held accountable for in their formation and structure?
  - Provider governance over medical policy or structure to ensure focus and aligned direction for the duals initiative. Providers should be encompassing of expertise from the behavioral health and long term care space.
  - The D-ACO must be capable of being a risk-bearing entity.
- Is there a need or a role for the Program Coordination Entity in the D-ACO model?

RISK ADJUSTMENT SUBGROUP OBJECTIVES

- Identify appropriate methods and data sources to calculate a projected baseline Total Cost of Care (TCOC) target
- Consider factors to be used to risk-adjust TCOC targets for individual ACOs, including beneficiary health status/functionality variation, geographic regions, and payment differences between facilities
- Consider how risk stratification methodology should be applied in the care coordination payment
- Determine how the ACO risk and reward formula will encourage appropriate delivery of high quality care.

PROPOSED BENEFICIARY COHORTS

Cohort	Sub-category	Description
Nursing Facility	None	Receiving long-term NF services in an institutional setting
HCBS Waiver	Under 65 / 65+	NF level of need, but receiving services that permit residence in a community setting
HCBS High Waiver	Under 65 / 65+	Meeting Waiver criteria, and incurring an average of at least $4,000 in waiver services alone per month
Community Dwelling	Under 65 / 65+	All other full duals in the target population

GROWTH- AND PROGRAM-BASED ADJUSTMENTS

- Trend will be applied to model natural increases in unit cost and utilization levels over time
- Programmatic changes will be considered:
  - Includes other types of interventions put into place since the base data time period
  - Consideration for certain duals currently enrolled in an ACO
  - Modifications to reimbursement and cost-sharing arrangements between Medicaid and Medicare
- Credibility adjustments may be needed for D-ACOs that enroll fewer beneficiaries

RISK ADJUSTMENTS

- D-ACO TCOC targets may be further adjusted based on:
  - Reimbursement differences between facilities attributed to a D-ACO
  - Health status/functionality assessments; adjustment for different RUGS and/or alternate Functional-Based Risk Adjustment (FBRA)
  - Geographic variations within the target population (separate TCOC targets may be developed by county or group of counties)

RISK ADJUSTMENTS

- How do we account for differences in the mix of populations across ACOs? Should an annual or a quarterly benchmark adjustment occur? Is there a higher need to do this process, or more often, in year one?
  - Does this appropriately incentivize and dis-incentivize the right type of care delivered at the right time?
- What assessments and mechanisms should be used to adjust for beneficiary risk?
  - InterRAI and DLA-20 are currently used and should be captured in the process.
  - Assessment-based risk adjustments, that are prospective, can be confounded with lags in targets and available data. A concurrent approach could support the process better and ensure appropriate attribution.

STRATIFYING CARE COORDINATION PAYMENTS

- Care coordination payments
  - To ensure providers are not paid multiple times for care coordination, we can:
    - Require providers to forgo claiming the care coordination fee for other programs
    - Create an additional sub-category population to identify beneficiaries in other programs.
  - Examples of programs include State Plan and 1915(c) waiver services, the Chronic Health Home Program and the Medicare Chronic Care Management fees
  - Flow of funds will go to the D-ACO with requirements on how they are down-streamed to PCHHs, which could include Chronic Health Homes and existing MSSP providers
- Care management fee is not part of the medical loss ratio but is part of budget neutrality

RISK-SHARING PERCENTAGE TIERS

- Minimum Savings or Loss Ratio
  - Intent of Minimum Savings or Loss Ratio is to:
    - Reduce random variation
    - Design a program that does not dis-incentivize ACOs from participating in the D-ACO program
    - Reward cost-savings and quality of care
- Consider phasing it in a risk-sharing tiered approach
  - Based on actual savings from benchmark
  - The more savings achieved by the particular D-ACO, the more percentage of savings can be attained
    - Losses would be less incremental than the savings. Delay sharing losses to year 3 potentially.
    - Designed to provide a greater share of savings to D-ACOs for greater savings

RISK-SHARING PERCENTAGE TIERS

A hypothetical representation of a tiered risk-sharing arrangement:

	Losses			Savings		
Actual Savings from Benchmark	5 - 10%	2 - 5%	0 - 2%	0 - 2%	2 - 5%	5 - 10%
Percent Shared by D-ACO	50%	25%	0%	25%	50%	75%
Incremental Gain/(Loss) for ACO	(2.50%)	(0.75%)	(0.00%)	0.50%	1.50%	3.75%
Cumulative Gain/(Loss) for ACO	(3.25%)	(0.75%)	(0.00%)	0.50%	2.00%	5.75%

QUALITY FACTORS

A hypothetical arrangement incorporating quality scores

	D-ACO Quality	Years 1-2	Year 3	Year 4
D-ACO's Share of Savings	High	60%	65%	70%
	Medium	50%	60%	60%
	Low	40%	35%	30%
D-ACO's Share of Losses	High	0%	35%	30%
	Medium	0%	40%	40%
	Low	0%	45%	50%

NEXT STEPS

- Data Analytics/Exchange Subgroup meeting September 26
- Additional meetings will be scheduled for Care Redesign and Risk Adjustment Subgroups
- Future workgroup meetings:
  - October 18, 1-4 pm
  - November 15, 1-4 pm
- Maryland Medicaid and EBG Advisors will continue to work with HSCRC, Public Health, CMMI, and other workgroups to detail out the model and its interaction with other programs